U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 27Aug2002

CASE NO.: 2001-BLA-901
2001-BLA-902

In the Matter of

VIRGINIA F. RAYNER Survivor of and on behalf of RAYMOND RAYNER
Claimant

v.

CONSOLIDATION COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Virginia F. Rayner
Pro Se Claimant

William S. Mattingly, Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS[1]

This proceeding arises from a miner's duplicate claim and a surviving spouse's claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed on December 2, 1999 and September 27, 2000, respectively. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their

[1] Sections 718.2 and 725.2(c) address the applicability of the new regulations to pending claims.

dependents;

2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,

3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal workers pneumoconiosis" "CWP") as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The miner filed his first prior claim for benefits on January 22, 1991. (Director's Exhibit ("DX") 1). The claim was denied, on June 14, 1991, and August 14, 1991. (DX 23-19; 23-21). His second claim, filed on May 31, 1994, was also denied, on August 19, 1994. (DX 24-17). His third claim, filed on February 5, 1998, was denied on July 14, 1998. (DX 25-20). The claim was denied because the evidence failed to establish the elements of entitlement. The miner's present and last claim was filed on December 2, 1999. It was denied because the evidence failed to establish the elements of entitlement, on April 5, 2000, and February 20, 2001. (DX 14 & 21). Mr. Rayner died on August 15, 2000.

The claimant filed her claim for benefits September 27, 2000. (Director's Exhibit Survivor's Claim ("WDX") 1). The claim was denied, on February 20, 2001, by the district director because the evidence failed to establish the elements of entitlement. (WDX 12). On March 9 and March 30, 2001, the claimant requested a hearing before an administrative law judge on both claims. (DX 22; WDX 15, 17). On June 12, 2001, the case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs (OWCP) for a formal hearing. (DX 27; WDX 21).

I was assigned the cases on January 31, 2002. On March 4, 2002, I consolidated the two claims for hearing. On May 10, 2002, I held a hearing in Wheeling, West Virginia, at which the employer was represented by counsel.[2] The claimant appeared *pro se*. No appearance was entered for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibit ("CX") 1, Director's exhibits ("DX") 1- 27 and WDX 1-21, and Employer's exhibits ("EX") 1- 7 were admitted into the record. A post-hearing deposition of Dr. Georges was permitted.

ISSUES

I. Whether the miner had pneumoconiosis as defined by the Act and the

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[2] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction. Under *Kopp v. Director, OWCP*, 877 F.2d 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction.

Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner was totally disabled?

IV. Whether the miner's disability and death were due to pneumoconiosis?

V. Whether there had been a material change in the miner's condition?

FINDINGS OF FACT

I. Background

A. Coal Miner[3]

The miner was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations,[4] for at least fourteen years. (Hearing Transcript (TR) 10).[5] Coal mine employment beyond this is inconsequential for purposes of this decision.

B. Date of Filing[6]

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[3] Former subsection 718.301(a) provided that regular coal mine employment may be established on the basis of any evidence presented, including the testimony of a claimant or other witnesses and shall not be contingent upon a finding of a specific number of days of employment within a given period. 20 C.F.R. § 718.301 now provides that it must be computed as provided by § 725.101(a)(32). The claimant bears the burden of establishing the length of coal mine employment. *Shelesky v. Director, OWCP*, 7 B.L.R. 1-34 (1984). Any reasonable method of computation, supported by substantial evidence, is sufficient to sustain a finding concerning the length of coal mine employment. *See Croucher v. Director, OWCP*, 20 B.L.R. 1-67, 1-72 (1996)(en banc); *Dawson v. Old Ben Coal Co.*, 11 B.L.R. 1-58, 1-60 (1988); *Vickery v. Director, OWCP, 8 B.L.R. 1-430, 1-432 (1986); Niccoli v. Director, OWCP*, 6 B.L.R. 1-910, 1-912 (1984).

[4] § 725.202 Miner defined; condition of entitlement, miner (Applicable to adjudications on or after Jan. 19, 2001).

(a) Miner defined. A "miner" for the purposes of this part is any person who works or has worked in or around a coal mine or coal preparation facility in the extraction, preparation, or transportation of coal, and any person who works or has worked in coal mine construction or maintenance in or around a coal mine or coal preparation facility. There shall be a rebuttable presumption that any person working in or around a coal mine or coal preparation facility is a miner. This presumption may be rebutted by proof that:

(1) The person was not engaged in the extraction, preparation or transportation of coal while working at the mine site, or in maintenance or construction of the mine site; or

(2) The individual was not regularly employed in or around a coal mine or coal preparation facility.

(Emphasis added).

[5] Where there is more than one operator for whom the claimant worked a cumulative total of at least one year, 20 C.F.R. § 725.493(a)(1) imposes liability on the most recent employer. *Snedecker v. Island Creek Coal Co.*, 5 B.L.R. 1-91 (1982)(§ 725.495(a) for claims filed on or after Jan. 19, 2001). One year of coal mine employment may be established by accumulating intermittent periods of coal mine employment. 20 C.F.R. § 725.493(c))(See § 725.101(32) for adjudications on or after Jan. 19, 2001). Under 718.301 (effective Jan. 19, 2001), the length of coal mine employment "must" be computed under 725.101(a)(32) criteria.

[6] 20 C.F.R. § 725.308 (Black Lung Benefits Act as amended, 30 U.S.C.A. §§ 901-945, § 422(f)).

(a) A claim for benefits filed under this part by, or on behalf of, a miner shall be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner or a person responsible for the care of the miner . . . There is no time limit on the filing of a claim by the survivor

The miner filed his claim for benefits, under the Act, on December 2, 1999. The claimant filed her claim for benefits, under the Act, on September 27, 2000. (WDX 1). None of the Act's filing time limitations are applicable; thus, the claims were timely filed.

C. Responsible Operator[7]

Consolidation Coal Company is the last employer for whom the miner worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart F (Subpart G for claims filed on or after Jan. 19, 2001), Part 725 of the Regulations.[8] (TR 10).

D. Dependents[9] and Survivorship

I find and the parties agreed that the miner had one dependent for purposes of augmentation of benefits under the Act, his wife. (TR 10). The parties agreed and I find Mrs. Rayner is an eligible survivor.

E. Personal, Employment and Smoking History[10]

The decedent miner was born on August 9, 1915. (DX 1). He married Virginia Rayner, the claimant on September 3, 1966. He claimed to have worked in the coal mines from twenty-six to thirty years. (DX 25-7). Mr. Rayner last worked in the mines in February 1980 when he retired. (DX 25-1). He worked primarily as a welder in the mine's machine shop. (DX 25-7). The miner's last position in the coal mines was that of a welder first class. (DX 25-4). The

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of a miner.
(c) There shall be a rebuttable presumption that every claim for benefits is timely filed . . . the time limits in this section are mandatory and may not be waived or tolled except upon a showing of extraordinary circumstances.

[7] Liability for payment of benefits to eligible miners and their survivors rests with the responsible operator, or if the responsible operator is unknown or is unable to pay benefits, with the Black Lung Disability Trust Fund. 20 C.F.R. § 725.493 (a)(1) defines responsible operator as the claimant's last coal mine employer with whom he had the most recent cumulative employment of not less than one year.

[8] 20 C.F.R. § 725.492. The terms "operator" and "responsible operator"are defined in 20 C.F.R.§ § 725.491 and 725.492. The regulations provide two rebuttable presumptions to support a finding the employer is liable for benefits: (1) a presumption that the miner was regularly and continuously exposed to coal dust; and (2) a presumption that the miner's pneumoconiosis **(disability or death and not pneumoconiosis for claims filed on or after Jan. 19, 2001)** arose out of his employment with the operator. 20 C.F.R. §§ 725.492(c) and 725.493(a)(6) (§§ 725.491(d) and 725.494(a) for claims filed on or after Jan. 19, 2001). To rebut the first, the employer must establish that there were *no* significant periods of coal dust exposure. *Conley v. Roberts and Schaefer Coal Co.*, 7 B.L.R. 1-309 (1984); *Richard v. C & K Coal Co.*, 7 B.L.R. 1-372 (1984); *Zamski v. Consolidation Coal Co.*, 2 B.L.R. 1-1005 (1980). To rebut the second, the operator must prove "within reasonable medical certainty or at least probability by means of fact and/or expert opinion based thereon that the claimant's exposure to coal dust in his operation, at whatever level, did not result in, or contribute to, the disease." *Zamski v. Consolidation Coal Co.*, 2 B.L.R. 1-1005 (1980). The second presumption has been rebutted in this case.

[9] See 20 C.F.R. §§ 725.204-725.211.

[10] "The BLBA, judicial precedent, and the program regulations do not permit an award based solely upon smoking-induced disability." 65 Fed. Reg. 79948, No. 245 (Dec. 20, 2000).

miner, as part of his duties as a welder, was required to stand eight hours and lift 40-50 plates daily. (DX 25-7). In 1998, he wrote he started having breathing problems in 1983. He could only walk about 20 feet without having to rest and slept propped-up. Mr. Rayner died on August 15, 2000.

There is evidence of record that the miner's respiratory disability may be due, in part, to his history of cigarette smoking.

II. Medical Evidence

The following is a summary of the evidence submitted.

A. Chest X-rays[11]

There were 27 readings of 32 X-rays, taken between 2/15/91and 8/13/00. (See Table below). Many were taken during hospitalizations and using portable X-ray equipment, thus many of the readings are not properly classified for pneumoconiosis, pursuant to 20 C.F.R. § 718.102 (b).[12] Only two readings are positive, by two physicians, Drs. Rothbaum and Noble. Only the latter is Board-certified in radiology and a B-reader.[13] Dr. Rothbaum has no radiological credentials of record. Thirty

readings are negative by physicians some of whom are either B-readers, Board-certified in radiology, or both.[14]

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[11] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

[12] ILO-UICC/Cincinnati Classification of Pneumoconiosis - The most widely used system for the classification and interpretation of X-rays for the disease pneumoconiosis. This classification scheme was originally devised by the International Labour Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs.

[13] *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading X-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. §37.51. Courts generally give greater weight to X-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993)."

[14] *Cranor v. Peabody Coal Co.*, 21 B.L.R. 1-201, BRB No. 97-1668 (Oct. 29, 1999) *on recon.* 22 B.L.R. 1-1 (Oct. 29, 1999)(*En banc*). Judge did not err considering a physician's X-ray interpretation "as positive for the existence of pneumoconiosis pursuant to Section 718.202(a)(1) without considering the doctor's comment." The doctor reported the category I pneumoconiosis found on X-ray was not CWP. The Board finds this comment "merely addresses the source of the diagnosed pneumoconiosis (& must be addressed under 20 C.F.R. § 718.203, causation)."

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
DX 23-15	02/15/91 03/12/91	Sargent	B; BCR	2		No CWP. Abnormal cardiac size or shape. Calcified granuloma.
DX 23-16	02/15/91 12/20/91	Rothbaum	none	1	1/1, s/s, 2 LZ	Dr. Altmeyer say "s" type opacities are inconsistent with CWP. (Dep. 24). CWP causes rounded opacities not irregular ones such as "s". (Dep. 25).
DX 23-20	07/19/91	R. Wall				No acute disease. No specific findings of CWP/silicosis.
WDX 10	11/02/93	G. Loh				No acute infiltrates.
DX 24-14	06/22/94 08/06/94	Sargent	B; BCR	2		Negative for CWP. Abnormal cardiac size or shape.
DX 24-13; WDX 10	06/22/94 06/24/94	Kennard	B; BCR	2	0/1, p/q, 3 LZ	Cardiac enlargement. Lungs fully expanded with no active process. Focal pneumonia not excluded. Changes could be chronic.
WDX 10	07/15/94	Benson				Compared to 11/2/93 film no significant interval change. No evidence of a-cute cardiopulmonary process. Mild cardiomegaly.
WDX 10	05/23/96	DeFilippo				Lungs well aerated, clear & no pleural fluid.
WDX 10	04/23/97	A. Seco		port-able		Other than chronic blunting of L. costo-phrenic sulcus, negative findings. No infiltrates.
WDX 10	05/31/97	Noble		port-able		Chronic changes L. base with minimal discoid atelectasis in bases & small r. effusion.
WDX 10	06/01/97	R. Stupar		port-able		Bilateral chronic changes. No acute process.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
WDX 10	02/27/98	M. Wymer		port-able		No active disease.
DX 25-11;WDX 10	03/06/98	T. Neis. Wheeling Hospital				Slight left ventricular enlargement. No acute consolidation in lung fields.
DX 25-11	03/07/98 03/07/98	Wymer		Port-able		No CWP. No infiltrate, effusion or failure. Tortuous aorta
DX 25-15;WDX 10	03/14/98 03/14/98	Caruso		Port-able		No CWP. Mild congestive failure.
DX 25-16	03/14/98 05/02/98	M. Sargent	B; BCR	3 very margin al		No CWP. Cardiomegaly. Abnormal cardiac size or shape.
WDX 10	08/06/98	Stupar		Port-able		A few chronic changes but no acute process.
WDX 10	10/29/98	Yost		Port-able		New patchy L. lobe infiltrate; post CABG.
WDX 10	11/08/98	R. Stupar		Port-able		L. Lower lobe infiltrate improved. Heart mildly enlarged.
WDX 10, 11	01/28/99	J. Yost		Port-able		Borderline cardiomegaly. No acute process.
WDX 11	01/29/99	P. Caruso		Port-able		No acute process. Pacemaker.
WDX 10	05/02/99	Yost		Port-able		No infiltrates or failure pattern. May be small bilateral effusions.
DX 6, 7	12/23/99 12/24/99	Noble	B; BCR	1	1/0, s/t, 6LZ	Mild cardiomegaly. Pacemaker. No active infiltrate or mass lesions. Pleural thickening left lung from CABG, not occupational lung disease.
DX 8	12/23/99 02/14/00	Gaziano	B	1		Negative. Illegible.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
DX 9	12/23/99 03/23/00	Sargent	B; BCR	1		Negative for CWP. Abnormal cardiac size or shape.
WDX 10	04/30/00	Patrizi				Probable R. lower lobe infiltrate.
WDX 10	05/02/00	Patrizi				Enlarged heart. Post-op changes. R. lower lobe pneumonia; increased area of infiltrate.
WDX 10	07/26/00	Patrizi				Enlarged heart. No focal consolidations.
WDX 10	08/06/00	R. Stupar				L.lower lobe infiltrate.
WDX 10	08/09/00	Capito				Equivocal worsening. onset R. mid-lung zone density favoring atelec-tasis &/or infiltrate. Left atelec-tasis &/or infiltrate.
WDX 10	08/10/00	Stupar				Unchanged bilateral infiltrates.
WDX 10	08/13/00	Carusi		portable		Increased bilateral infiltrates+ small amount effusion.

* A- A-reader; B- B-reader; BCR- Board-certified radiologist; BCP-Board-certified pulmonologist; BCI= Board-certified internal medicine; BCI(P)= Board-certified internal medicine with pulmonary medicine sub-specialty. Readers who are Board-certified radiologists and/ or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 N.16, 98 L.Ed. 2d 450 (1987) and, *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

** The existence of pneumoconiosis may be established by chest X-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest X-ray classified as category "0," including subcategories "0/-, 0/0, 0/1," does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp.*, 6 B.L.R. 1-307 (1983)(Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997))*(en banc*)(*Unpublished*). If no categories are chosen, in box 2B(c) of the X-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.

B. Pulmonary Function Studies[15]

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

Physician Date Exh.#	**Age Height**	**FEV_1**	**MVV**	**FVC**	**Tra-cings**	**Compr e-hension Cooper-ation**	**Qualify * Conf-orm****	**Dr.'s Impression**
Rothbaum 02/15/91 DX 23-11	75 63"	1.86 2.03+		2.91 2.76+	Yes	Good Good	No* Yes** No* Yes**	Possible mild-moderate obstructive disease. Fino finds invalid. (EX 2).Dr. Altmeyer finds mild obstructive impairment. (EX 6).
DX 23-20	75 66"	1.97		2.81			No* No**	Possible mild-moderate obstructive disease.
07/19/91 DX 23-20	75 66"	1.97		2.81	Yes		No* Yes**	Possible mild-moderate obstructive disease. Dr. Rosenberg finds mild air flow obstruction. (Dep. 17).Fino finds normal. (EX 2). Altmeyer finds no significant obstruction. (Dep. 26).
Del Vecchio 06/22/94 DX 24-8	79 65"	1.00	23	1.67	Yes	Good Good	Yes* No**	Mild obstructive pulmonary disease. Severe small airway disease. PFS accept-able. (DX 24-9). Dr. Long believes less than optimal effort. (WDX 13). Dr. Rosenberg finds invalid. (Dep. 19). Fino finds invalid. (EX 2).

[15] § 718.103 (a)(Effective for tests conducted after Jan. 19, 2001(see 718.101(b))), provides: "Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop)." 65 Fed. Reg. 80047 (Dec. 20, 2000). In the case of a deceased miner, where no pulmonary function tests are in substantial compliance with paragraphs (a) and (b) and Appendix B, noncomplying tests may form the basis for a finding if, in the opinion of the adjudication officer, the tests demonstrate technically valid results obtained with good cooperation of the miner. 20 C.F.R. § 718.103(c).

Physician Date Exh.#	**Age Height**	**FEV_1**	**MVV**	**FVC**	**Tra-cings**	**Compr e-hension Cooper-ation**	**Qualify * Conf-orm****	**Dr.'s Impression**
OVMC/ Lenkey 03/06/98 DX 25-14	82 65"	1.47 1.52	36	2.25 2.17	Yes		Yes* Yes** No* Yes**	Mild obstructive airway disease. Markedly diminished pulmonary reserve. Slightly decreased diffusion capacity. Fino finds mild obstruction but invalid MVV. (EX 2). Dr. Rosenberg finds normal. (Dep. 22).Dr. Altmeyer finds mild airways obstruction. (Dep. 28).
Reddy 12/23/99 DX 2	84 65"	1.03	25	2.04	Yes		Yes* No**	Moderate obstructive airway disease. Dr. Joseph J. Renn, III, (BCI(P)) finds solidly invalid. (DX 19). Found acceptable by Dr. Katzman on a form w/o explanation. (DX 3). Fino finds invalid. (EX 2). Altmeyer doubts validity. (Dep. 30).

* A "**qualifying"** pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.
** A study "**conforms**" if it complies with applicable quality standards (found in 20 C.F.R. § 718.103(b) and (c)). (*see Old Ben Coal Co. v. Battram*, 7 F.3d. 1273, 1276 (7th Cir. 1993)). A judge may infer, in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).
+Post-bronchodilator.

Appendix B (Effective Jan. 19, 2001) states: "(2) The administration of pulmonary function tests shall conform to the following criteria:
(i) Tests shall not be performed during or soon after an acute respiratory illness. . ."

Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed "unacceptable" when the subject "[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV1's of the three acceptable tracings should not exceed 5 percent of the largest FEV1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve this degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test." (Emphasis added).

For a miner of the miner's height of 65 inches, § 718.204(b)(2)(i) requires an FEV_1 equal

to or less than 1.48 for a male 84 years of age.[16] If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 1.92 or an MVV equal to or less than 59; or a ratio equal to or less than 55% when the results of the FEV1 test are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ratio requirement remains constant.

Height	Age	FEV_1	FVC	MVV
63"	75	1.32	1.73	53
65"	79	1.48	1.92	59
65"	82	1.48	1.92	59
65"	84	1.48	1.92	59

C. Arterial Blood Gas Studies[17]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange.[18] This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Ex.#	**Physician**	**PCO_2**	**PO_2**	**Qualify**	**Physician Impression**
06/06/91 DX 23-20	Rothbaum	39	82	No	Dr. Rosenberg finds normal. (Dep. 14, 17).

[16] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP,* 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.,* 43 F.3d 3 (4th Cir. 1995). I find the miner is 65" here, the most often reported height.

[17] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. § 718.204(b)(2) permits the use of such studies to establish "total disability." It provides:
In the absence of contrary probative evidence, evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability: . . .
(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part . . .

[18] 20 C.F.R. § 718.105(d) (Applicable Jan. 19, 2001) states:
"If one or more blood-gas studies producing results which meet the appropriate table in Appendix C is administered during a hospitalization which ends in the miner's death, then any such study must be accompanied by a physician's report establishing that the test results were produced by a chronic respiratory or pulmonary condition. Failure to produce such a report will prevent reliance on the blood-gas study as evidence that the miner was totally disabled at death."

Date Ex.#	Physician	PCO_2	PO_2	Qualify	Physician Impression
02/15/91 DX 23-13	Lung Lab Rothbaum	39	70	No	Normal. Fino finds normal. (EX 2).Dr. Altmeyer finds normal. (EX 6).
03/06/98 DX 25-14	Lenkey	41.7	82.3	No	Invalid because taken in ER. Normoxemia & normocarbia. O2 only slightly diminished. Dr. Rosenberg finds normal. (Dep. 22).Dr. Altmeyer finds normal. (Dep. 28).
12/23/99 DX 5	Reddy	40.4	76.8	No	Fino finds normal. (EX 2). Dr. Altmeyer finds normal. (Dep. 33).

+ Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b). Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respiratory or cardiac illness."

D. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(a)(4). Where total disability cannot be established, under 20 C.F.R § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work.
§ 718.204(b).

Dr. Venu Reddy, whose qualifications are not in the record, examined the miner on January 19, 2000. His report, based upon his examination of the miner notes 53 years of coal mine employment and a 36-year pack per day smoking history, ending in 1966. (DX 4). Based on an EKG, a non-qualifying arterial blood gases, a qualifying pulmonary function study, and a positive chest X-ray, Dr. Reddy diagnosed: chronic bronchitis from cigarette smoking and exposure to coal mine dust; COPD; simple CWP from exposure to coal mine dust; and, bilateral pleural thickening from exposure to asbestos. He found the miner about 60% impaired of which half was attributable to coal dust exposure. (DX 4).

Dr. Jerome Rothbaum, whose credentials are not in the record, examined the miner, on February 15, 1991, and submitted a report. (DX 23-12). He noted a 43-year history of coal mine employment and a half-to-a-pack per day smoking history until 26 years earlier (1965). An EKG revealed no changes of MI, but a sinus rhythm with multiple atrial premature contractions. Dr. Rothbaum diagnosed: COPD which the evidence "suggests" is due in part to CWP; probable

CWP; possible Parkinsonism; ASCVD; history of renal lithiasis He found a mild-to-moderate impairment, 50% of which was attributable to coal mine dust exposure. (DX 23-12).

Dr. James DelVecchio, whose credentials are not in the record, examined the miner on July 6, 1994 and submitted a report. (DX 24-10). He noted 39 years of coal mine employment and a 31-year, ½-pack or less per day smoking history, ending in 1966. He also noted the miner's pre-welder work digging and loading coal and driving a coal truck. Dr. DelVecchio reported the miner's complaints that he could walk only a block or climb a flight of stairs without dyspnea and avoided lifting or carrying. The miner's history included hypertension and heart disease. Based on history, a "0/1" X-ray, a pulmonary function test showing mild chronic obstructive pulmonary disease, examination and a normal EKG, he diagnosed CWP due to coal dust and other inhalants in coal mining, coal trucking, machine shop, steel mill and welding. While Dr. DelVecchio reported a "0%" disability, he also wrote disability was probably due to cigarette smoking and "insufficient evidence of pneumoconiosis." (DX 24-10).

Dr. David M. Rosenberg is a B-reader and is Board-certified in internal medicine with a sub-specialty in pulmonary medicine and occupational diseases. (WDX 13). His consultation report, dated February 13, 2001, based upon his thorough examination of enumerated records relating to the miner, notes 52 years of coal mine employment and a lengthy smoking history ending over twenty years prior to his death. (WDX 13). He observed that PFS performed during the latter stages of Mr. Rayner's life were performed with inadequate and inconsistent efforts and did not meet ATS criteria for valid interpretation. Dr. Rosenberg wrote that based on his review, "the worst case scenario is that Mr. Rayner had a simple pneumoconiosis. . . it would not have caused respiratory impairment. Simple coal workers' pneumoconiosis is not associated with any clinically significant respiratory impairment." Although he did not see the X-rays himself, Dr. Rosenberg observed that most readers found cardiac decompensation, pneumonia, and post-operative changes, rather than abnormalities of CWP. His earlier PFS, when he could provide good effort, showed he had normal lung volumes without evidence of restriction. He did have a mild airflow obstruction. Dr. Rosenberg concluded Mr. Rayner did not have simple CWP or any impairment "consequent to the presence of coal workers' pneumoconiosis or the past inhalation of coal dust." His valid PFS show he was capable of performing his last coal mine work prior to his death.

Dr. Rosenberg concluded Mr. Rayner's death was not caused by CWP or any complication of the inhalation of coal dust. He wrote, "His death related to his underlying cardiac condition with aspiration pneumonias, renal insufficiency, and a general deteriorating state. It had nothing to do with coal workers' pneumoconiosis. His death at age 85 would have occurred independently of whether or not he previously was exposed to coal dust."

Dr. Rosenberg testified at a deposition, on April 27, 2001. (EX 1). He reiterated his credentials and the substance of his earlier report. He testified that, "[I]t would be extremely improbable that one develops *de novo* coal workers' pneumoconiosis 40 years after they left the

mines." (Dep. 12).[19] One would expect a miner to have some evidence of CWP when he left the mines, not to develop it de novo later. (Dep. 12). Hypertension is a major risk factor for stroke and heart disease. Mr. Rayner had major hypertension which contributed to his progressive renal failure, TIA, CHF, heart disease, and stroke. (Dep. 13). Mr. Rayner's symptoms of cough, shortness of breath and decreased breath sounds with rales was probably related to components of his CHF and vascular congestion. (Dep. 14). That is particularly true since the rales came and went. (Dep. 16). Moreover, his oxygen saturation were over 90 percent at rest and with exercise implying his gas exchange capability was in tact and unaffected by any CWP. (Dep. 15). Had he been healthier, he might have been a candidate for yet another CABG .

Mr. Rayner's mild obstructive impairment was undoubtedly related to his earlier heavy smoking history. (Dep. 17). The shortness of breath he reported in 1991 was not from a lung disease. (Dep. 18). The blunting and abnormality of the costo phrenic angle shown on X-ray suggests fluid accumulation from CHF, fluid overload and vascular congestion. (Dep. 20). Mr. Rayner's tests from the 1997 Wheeling Hospital admission show he had fluid overload, coronary artery blockage, chronic renal failure, and only about 5 percent normal kidney function. (Dep. 20). Abnormal renal function affects the ability of the lungs to function normally. (Dep. 21). The miner had cardiomegaly. Dr. Rosenberg believes that Mr. Rayner's terminal admission records do not show his difficulties were primarily due to pulmonary or lung disorders. (Dep. 24). The mechanism of death was "probably related to worsening renal failure, fluid overload, cerebral vascular disease, further strokes", aspiration and increasing heart failure. (Dep. 25). He did not suffer from CWP. (Dep. 25). Even if he had CWP it did not cause any ventilatory impairment. The mild obstruction he had was readily explained by his prior smoking. (Dep. 27). Mr. Rayner's death was neither caused nor hastened by disease arising out of coal mine employment. (Dep. 27).

Dr. Rosenberg concluded:

> He was an 85-year old gentleman who had multiple organ failure to his kidneys, his heart, his brain, multiple strokes and TIAs . . . gangrenous foot requiring amputation. Unfortunately, he died, but it was a natural progression of multiple medical conditions that he had. It really wasn't related to a coal workers' pneumoconiosis or any primary lung condition. (Dep. 28).

Dr. Angelo Georges was deposed on July 9, 2002. (EX 7). Dr. Georges is not board-certified, but did a three-year internal medicine residency and has an interest in infectious diseases. He admitted not having the level of expertise to distinguish between CWP and emphysema and would refer such cases to a specialist. (Dep. 9). Mr. Rayner had a CWP diagnosis when he came to Dr. Georges, who did not make that diagnosis on his own accord. (Dep. 11). He observed Mr. Rayner had lung disease based on chest X-rays, AGS, and "that sort of thing." He also believed he suffered from cor pulmonale and cardio-myopathic symptoms and congestive heart failure. (Dep. 12-13). He admitted CHF can be caused by a whole series of conditions, such as

[19] The "40" year figure appears to be a misstatement or stenographical error. He was asked about 6-7 years post coal mining. Mr. Rayner ceased mining in 1980.

ischemic CAD. Mr. Rayner's renal failure was due to his peripheral vascular disease. (Dep. 20).

Dr. Georges did not treat the miner for CWP or his lung disease, but for his renal insufficiency and coronary disease. (Dep. 24). He explained that anybody who smokes and develops CWP-that is atherogenic and one develops cor pulmonale. He felt CWP "certainly it is a causal factor indirectly" for his atherosclerosis or arterial sclerosis of his peripheral vascular disease. (Dep. 23). The miner was short of breath when Dr. Georges began seeing him in 1993. (Dep. 23). As a smoker, COPD was added in - that seemed the primary risk factor for his development of cardiac disease. (Dep. 23-24). Dr. Georges would not expect simple CWP to cause pulmonary disability in a young, active, miner. Nor would one with early radiographic evidence of CWP have such a disability. (Dep. 25).

Dr. Gregory Fino, who is Board-certified in internal medicine with a sub-specialty in pulmonary diseases, and is a B-reader, reviewed the claimant's medical records on behalf of the employer and submitted his opinions in a comprehensive report, dated October 24, 2001. (EX 2). His consultation report notes 39 years of coal mine employment and a detailed, heavy and lengthy smoking history. Dr. Fino concluded that the claimant did not have pneumoconiosis, but that at the most he had a mild obstructive disorder due to his smoking. Mr. Rayner did not have a respiratory disability during his lifetime. He concluded Mr. Rayner had severe renal failure and severe, inoperable CAD which predisposed him to aspiration pneumonia which caused his death. Dr. Fino opined even if Mr. Rayner had CWP it would not have cause a disability and in no manner contributed to his death.

The employer submitted the consultation report of Dr. Robert A. Altmeyer, dated October 29, 2001. (EX 4). Dr. Altmeyer is a B-reader and board-certified in internal medicine with sub-specialties in pulmonary medicine and geriatric medicine. (EX 5). He reviewed 125 enumerated records and reports concerning Mr. Rayner. He concluded the miner did not have CWP, silicosis, or any other dust disease arising out of coal mine employment. The radiologists never described changes consistent with CWP. Simple CWP does not cause crackles. The PFS pattern of mild obstruction with reversibility is inconsistent with CWP. His productive cough which persisted long after he left the mines which show he did not suffer from industrial bronchitis which clears within six months to a year after cessation of mining. Since Mr. Rayner had no chronic dust disease arising out of coal mine employment, "it is impossible that his death was caused or contributed to by any such disease." (EX 4).

Dr. Altmeyer was deposed on January 3, 2002. (EX 6). He reiterated the substance of his earlier report and his credentials. He added neither of the medications Mr. Rayner was being treated with, i.e., bronchodilators, are helpful in treating CWP. (Dep. 15). Moreover, Mr. Rayner was developing cardiac disease, e.g., CAD, over a long time period. (Dep. 17-18). The crackles found on examination are not associated with simple CWP, but rather PMF.

Dr. Altmeyer testified that coal mine dust exposure has had no effect on Mr. Rayner's lungs, according to the July 1991 PFS. (Dep. 26). He observed the miner had severe CAD, HBP, and a mild leak of the mitral valve. (Dep. 28). The changes between the 1998 and 1999 PFSs are not from CWP, because it is too rapid whereas CWP causes a gradual reduction. (Dep.

32). Dr. Altmeyer does not agree with Dr. Reddy's findings because the PFS was invalid and other X-ray readers did not agree with Dr. Noble's reading. He concluded that the miner's lung functions would deteriorate when he was having cardiac dysfunction, but otherwise he had excellent lung function with either no airways obstruction or mild obstruction. (Dep. 33). His heart's malfunctions had a dramatic effect on his lungs. (Dep. 33). Mr. Rayner died primarily of aspiration pneumonia, a common way to die when elderly and suffering multiple medical problems. (Dep. 37). If Mr. Rayner had any lung function impairment, it was variable and mild and would not have precluded heavy labor. (Dep. 37). Even had he suffered from CWP, it neither caused any impairment nor hastened or contributed to his death. (Dep. 38).

III. Hospital Records & Physician Office Notes

Two records of Emergency room visits, on May 31, 1997 and March 7, 1998, for chest and shoulder pain were admitted. (DX 25-14). In 1997, Dr. Kovalick reported a diagnosis of chronic renal failure, unstable angina, and a history of COPD. Dr. Kovalick noted the miner's triple by-pass surgery on January 30, 1990. His catheterization, in 1997, showed a 100 % occluded left circumflex and a 100 % occluded coronary artery. In 1998, Dr. Kovalick reported an EKG with normal sinus rhythm with an apparent right bundle branch block. He found significant coronary artery disease. Upon consultation with Dr. Georges, the family physician, it was determined the miner was "not a candidate for surgical intervention." MI was ruled out, but he was diagnosed with unstable angina.

Mr. Rayner had visited numerous physicians over the years with complaints of shortness of breath and chest pains. (DX 25-9). He submitted a 206-page exhibit covering these, multiple laboratory tests, and hospital visits from 1988 through 1991. The records reflect the following:

In 1991, Dr. Christopher Wintzer opined the miner was totally disabled and showed signs of obstructive lung disease. His (negative) X-ray showed some blunting with scarring. Thus, with his history of coal mine employment, shortness of breath, limited smoking history, and PFS results, he believed the miner had CWP. The miner visited Dr. Wintzer frequently with complaints of shortness of breath, weakness, dizziness, and productive cough well after he had ceased smoking. The doctor noted his CABG and diagnosed COPD with CWP from being a coal miner. He felt his cardiac function was borderline with probable congestive heart failure or cardiac decompensation. The miner had CAD with generalized atherosclerotic disease, as early as 1989.

X-ray readings from the period reflect no active disease process, but some residual scarring in the left hemithorax with a superimposed approximate 7 mm calcified nodule, patchy bibasilar parenchymal disease, atelectasis and mild cardiomegaly. EKGs revealed sinus bradycardia. Drs. Algeo, McDonald, and Michael Smith followed his heart problems and CABG. They noted his history of CAD and angina. Mr. Rayner was hospitalized 12/14-12/17/ 1990 for dyspnea post-CABG.

A short, two-paragraph letter from Dr. Angelo Georges was admitted. (CX 1). He wrote:

> As it has been well documented, Raymond suffered from severe coal workers' pneumoconiosis, i.e., black lung. Certainly, this is a strong contributing factor to his general downward trend in his health over recent years, and his eventual death. Additionally, he did have some significant cor pulmonale as a result of his pneumoconiosis.
>
> In summary, I feel strongly that his underlying lung disease was a major factor contributing to his death. . .

Records from Thoracic and Cardiovascular Surgery, Inc., and the Ohio Valley Medical Center covering the period of March 1992 through 2000 were admitted. (WDX 6). Some are handwritten and illegible. The records reflect treatment for "sick sinus syndrome"; implantation of a cardiac pacemaker; prostate cancer; hernia repair; and, amputation below the right knee. They also show Mr. Rayner had a right and left carotid endarterectomy in 1991 as well as CABG in 1990.

Records from the Ohio Valley Medical Center covering the period of March 1992 through 2000 were admitted. (WDX 10). They reflect Mr. Rayner's heart catheterization, coronary angiography, and ventriculography, by Dr. Adel Frenn. His history of CAD is noted. They show his right and left coronary arteries were 100 per cent occluded, in April 1997. A May 5, 1999, discharge summary, following admission for chest pain, reflects his history of CAD and MIs, as well as coughing and shortness of breath. An emergency room record of 4/30/00, shows diagnoses of: transient ischemic attack; chronic renal failure; and right middle lobe pneumonia. In July 2000, Dr. Parenteau reported the miner had severe, end-stage renal disease, congestive heart failure, and inoperable ischemic cardiomyopathy. His terminal admission record, signed by Dr. Angelo Georges, shows a DNR order, as of 8/12/00. His terminal diagnoses included: COPD; CABG; CHF; atelectasis; aspiration pneumonia; hypothyroidism; chronic ischemic heart disease; pacemaker; hypokalemia; hypocalcemia; and, glaucoma.

Medical records from the Ohio Valley Medical Center, dated November 8, 1998 through July 30, 2000, were admitted as WDX 11. They reflect Mr. Rayner's admissions and or treatment for angina, chest pain, and diagnoses of acute myocardial infarction, hypertension, chronic renal failure, sick sinus syndrome, and unstable angina. Implantation of a cardiac pacemaker is reflected. A 2/2/99 discharge summary reflects diagnoses of: COPD; unstable angina; bradycardia history; acute myocardial infarction; hypothyroidism; hypertensive renal disease prostate carcinoma; cerebrovascular accident history; CABG. Some terminal admission records are repeated which reflect severe ischemic cardiomyopathy.

IV. Death Certificate

The death certificate lists the date of death as August 15, 2000. (WDX 2). The immediate cause of death was pneumonia and other significant conditions contributing to death but not resulting in the underlying cause stroke and ischemic cardiomyopathy. (WDX 2). No autopsy was performed. (WDX 2). Dr. John Holloway was the signing/certifying physician.

V. Witness' Testimony

Mrs. Rayner testified that the miner had breathing problems and that Dr. Raczkowski told her he had very bad lungs due to coal miner's work. (TR 17). Mr. Rayner had heart by-pass surgery in January 1990, but had fully recovered. (TR 17-18). Mr. Rayner smoked, but not that often, according to Mrs. Rayner. (TR 17). Between July 1998 and his date of death, he was on oxygen all the time. He could hardly walk and coughed all the time. (TR 18). He began using oxygen in 1990. Mr. Rayner took a turn for the worse in 1997, getting weaker, coughing more, and getting more colds. (TR 19).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) the miner had pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he was totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). *See Lane v. Union Carbide Corp.*, 105 F.3d 166, 170 (4th Cir. 997). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP, v. Mangifest*, 826 F.2d 1318, 1320 (3d Cir. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986).

Since this is the miner's fourth claim for benefits, the claimant must initially show that there has been a material change of conditions.[20]

To assess whether a material change in conditions is established, the Administrative Law Judge ("Administrative Law Judge") must consider all of the new evidence, favorable and unfavorable, and determine whether the claimant has proven, at least one of the elements of

[20] Section 725.309(d) provides, in pertinent part:

> In the case of a claimant who files more than one claim for benefits under this part, . . . [i]f the earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless the [Director] determines there has been a material change in conditions . . . (Emphasis added).

entitlement previously adjudicated against him in the prior denial.[21] *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996) (*en banc*) *rev'g* 57 F.3d 402 (4th Cir. 1995), *cert. den*. 117 S.Ct. 763 (1997); *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994); and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308, 20 B.L.R. 2-76 (3d Cir. 1995). *See Hobbs v. Clinchfield Coal Co.* 917 F.2d 790, 792 (4th Cir. 1990). If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Unlike the Sixth Circuit in *Sharondale*, the Fourth Circuit does not require consideration of the evidence in the prior claim to determine whether it "differ[s] qualitatively" from the new evidence. *Lisa Lee Mines*, 86 F.3d at 1363 n.11. The Administrative Law Judge must then consider whether all of the record evidence, including that submitted with the previous claim, supports a finding of entitlement to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994) and *LaBelle Processing Co. v. Swarrow*, 72 F. 3d 308 (3rd Cir. 1995).

The miner's prior application for benefits was denied because the evidence failed to show that: (1) the miner had pneumoconiosis; (2) the pneumoconiosis arose, at least in part, out of coal mine employment; and (3) the miner was totally disabled by pneumoconiosis. Under the *Sharondale* standard, the claimant must show the existence of one of these elements by way of newly submitted medical evidence in order to show that a material change in condition has occurred. If he can show that a material change has occurred, then the entire record must be considered in determining whether he is entitled to benefits. *Sharondale*.

As discussed in greater detail below, the claimant has not established a material change in conditions in the miner's claim.

Part 718 applies to survivors' claims which are filed on or after April 1, 1980. 20 C.F.R. § 718.1. There are four possible methods of analyzing evidence in a survivor's claim under Part 718: (1) where the survivor's claim is filed prior to January 1, 1982 and the miner is entitled to benefits as the result of a living miner's claim filed prior to January 1, 1982; (2) the survivor's claim is filed prior to January 1, 1982 and there is no living miner's claim or the miner is not found entitled to benefits as the result of a living miner's claim filed prior to January 1, 1982; (3) the survivor's claim is filed after January 1, 1982 and the miner was found entitled to benefits as the result of a living miner's claim filed prior to January 1, 1982; and (4) the survivor's claim is filed on or after January 1, 1982 where there is no living miner's claim filed prior to January 1, 1982 or the miner is found not entitled to benefits as a result of a living miner's claim filed prior to January 1, 1982. The fourth, Subsection 718.205(c) applies to this claim.[22]

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[21] *Madden v. Gopher Mining Co.*, 21 B.L.R. 1-122, BRB No. 98-0714 BLA (Feb. 19, 1999). Lay testimony, standing alone, regarding the miner's worsened condition, since the denial of his last claim, is insufficient to establish a material change of condition, under 20 C.F.R. § 725.309, absent corroborating medical evidence.

[22] The survivor is not entitled to the use of lay evidence, or the presumptions at §§ 718.303 and 718.305 to aid in establishing entitlement to survivors' benefits. A survivor is automatically entitled to benefits only where the miner was found entitled to benefits as a result of a claim filed prior to January 1, 1982. However, a survivor is not automatically entitled to such benefits under a claim filed on or after January 1, 1982 where the miner is not entitled to benefits as a result of the miner's claim filed prior to January 1, 1982 or where no miner's claim was filed prior to January 1, 1982. *Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988).

The Part 718 regulations provide that a survivor is entitled to benefits only where the miner *died due to pneumoconiosis.* 20 C.F.R. § 718.205(a). As a result, the survivor of a miner who was totally disabled due to pneumoconiosis at the time of death, but died due to an unrelated cause, is not entitled to benefits. 20 C.F.R. § 718.205(c). Under § 718.205(c)(4)(2001), if the principal cause of death is a traumatic injury or a medical condition unrelated to pneumoconiosis, the survivor is not entitled to benefits unless the evidence establishes that pneumoconiosis was a substantially contributing cause of the death.

The regulations now provide and the Board has held that in a Part 718 survivor's claim, the Judge must make a threshold determination as to the existence of pneumoconiosis arising out of coal mine employment, under 20 C.F.R. § 718.202(a), prior to considering whether the miner's death was due to the disease under § 718.205. 20 C.F.R. § 718.205(a); *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993).

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment."[23] 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.[24]

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[23] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director,* 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1364; *LaBelle Processing Co. v. Swarrow,* 72 F.3d 308 (3d Cir. 1995) at 314-315. In *Henley v. Cowan and Co.*, 21 B.L.R. 1-148 (May 11, 1999), the Board holds that aggravation of a pulmonary condition by dust exposure in coal mine employment must be "significant and permanent" in order to qualify as CWP, under the Act.

[24] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.
(Emphasis added).

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[25] Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

" . . . [T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP,* 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing, Rose v. Clinchfield Coal Co.*, 614 F. 2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[26] 20 C.F.R.
§ 718.202(a)(4).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R.
§ 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is

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[25] The definition of pneumoconiosis, in 20 C.F.R. section 718.201, does not contain a requirement that "coal dust specific diseases . . . attain the status of an "impairment" to be so classified. The definition is satisfied "whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question." Moreover, the legal definition of pneumoconiosis "encompasses a wide variety of conditions; among those are diseases whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. *See*, e.g., *Warth*, 60 F.3d at 175." *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4th Cir. June 25, 1999) at 625.

[26] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel*, 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, *i.e.* X-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under
§ 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim filed after Jan. 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence.[27] 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP.[28] "[W]here two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." *Id.; Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985)."(Emphasis added). (Fact one is Board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n. 5 (1985).

A judge is not required to defer to the numerical superiority of X-ray evidence, although it is within his or her discretion to do so. *Wilt v. Woverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). This is particularly so where the majority of negative readings are by the most qualified physicians. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31, 1-37 (1991). Here, only two of the thirty-two X-ray readings were positive for CWP. One was from Dr. Rothbaum who lacks any radiological qualifications of record. Moreover, dually-qualified Dr. Sargent read the same X-ray negative and the well-qualified Dr. Altmeyer criticized Dr. Rothbaum's interpretation. Dr. Noble's "1/0" reading was contradicted by the negative readings of Drs. Gaziano and Sargent. Moreover, Dr. Noble himself wrote that the pleural thickening in the left lung was from CABG not occupational lung disease. Given these facts and the long history of negative readings, I can not find the X-ray evidence establishes CWP alone or in conjunction with the other evidence.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and

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[27] "There are twelve levels of profusion classification for the radiographic interpretation of simple pneumoconiosis. . . *See* N. LeRoy Lapp, '*A Lawyer's Medical Guide to Black Lung Litigation*,' 83 W. VA. LAW REVIEW 721, 729-731 (1981)." Cited in *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1359, n. 1.

[28] See Footnote 4.

supported by a

reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it. *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of their various Board-certifications, B-reader status, and expertise, as noted above, I rank Drs. Fino, Rosenberg, and Altmeyer, as the best qualified to render opinions in this matter.

There is a distinction between a physician who merely examines a miner and one who is one of his "treating" physicians.[29] Dr. Georges was Mr. Rayner's treating physician for many years. As such, generally his opinion would ordinarily be entitled to more weight as he was more likely to be familiar with the miner's condition than a physician who examined him episodically.[30]

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[29] "Treatment" means "the management and care of a patient for the purpose of combating disease or disorder." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, p. 1736 (28th Ed. 1994). "Examination" means "inspection, palpitation, auscultation, percussion, or other means of investigation, especially for diagnosing disease, qualified according to the methods employed, as physical examination, radiological examination, diagnostic imaging examination, or cystoscopic examination." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, p. 589 (28th Ed. 1994).

[30] § 718.104(d) Treating physician (Jan. 19, 2001). In weighing the medical evidence of record relevant to whether the miner suffers, or suffered, from pneumoconiosis, whether the pneumoconiosis arose out of coal mine employment, and whether the miner is, or was, totally disabled by pneumoconiosis or died due to pneumoconiosis, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the adjudication officer shall take into consideration the following factors in weighing the opinion of the miner's treating physician:

(1) Nature of relationship. The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;

(2) Duration of relationship. The length of the treatment relationship demonstrates whether the physician has observed the miner long enough to obtain a superior understanding of his or her condition;

(3) Frequency of treatment. The frequency of physician-patient visits demonstrates whether the physician has observed the miner often enough to obtain a superior understanding of his or her condition; and

(4) Extent of treatment. The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition.

(5) In the absence of contrary probative evidence, the adjudication officer shall accept the statement of a physician with regard to the factors listed in paragraphs (d)(1) through (4) of this section. In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the

Onderko v. Director, OWCP, 14 B.L.R. 1-2 (1989); *Jones v. Badger Coal Co.*, 21 B.L.A. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*)(Proper for judge to accord greater weight to treating physician over non-examining doctors).[31] However, in this matter I do not accord his opinion much weight as he admitted he had neither diagnosed nor treated the miner for CWP or pulmonary afflictions, but rather had merely accepted a CWP diagnosis based on the miner's medical history. He testified he would have to defer to the opinions of pulmonary specialists lacking such expertise himself. His diagnoses on the miner's terminal admission records do not list CWP among the miner's myriad afflictions. Finally, his testimony was confusing and not well-reasoned or documented.

Other than Dr. Georges, only Drs. Wintzer, Reddy, Rothbaum, and DelVecchio diagnosed CWP. None of their credentials are of record. Dr. Wintzer diagnosed CWP, COPD from coal dust exposure and total disability from CWP, in 1991. However, his observations are contained in the miner's hospitalization records and the doctor did not adequately provide his reasoning. The non-qualifying PFS Dr. Wintzer relied on does not support his diagnosis nor do the negative X-rays. Likewise, Dr. Rothbaum diagnosed "probable CWP" in 1991. In the early 1990's, none of the miner's PFS or AGS had "qualifying" values illustrating he did not have a total respiratory disability due to CWP and his X-rays, other than the one discredited reading by Dr. Rothbaum, were uniformly negative for CWP. Dr. DelVecchio had a "qualifying" PFS, in July 1994, but I found it non-conforming based upon the opinions of Drs. Fino, Rosenberg, and Long. Moreover, Dr. DelVecchio inconsistently relied on a "0/1" X-ray in reaching his CWP diagnosis. Then he wrote "insufficient evidence of CWP". I find his opinion unreliable. None of the doctors diagnosing CWP, other than Dr. Wintzer, found the miner suffered from a total respiratory disability.

On the other hand, the very well-qualified, pulmonary experts, Drs. Fino, Rosenberg, and Altmeyer, found Mr. Rayner suffered from a mild to moderate reversible obstructive lung disease and no CWP or occupational dust disease. Each of their reports and evaluations is extremely thorough and very well reasoned. Dr. Altmeyer, in fact, considered 125 different medical reports, tests, opinions, etc.. These pulmonary specialists all agreed the miner's obstructive disease was caused by his cigarette smoking and he neither had CWP nor any respiratory disability due to an occupational lung disease. As these doctors pointed out, the miner's more recent PFS do not provide a basis for an accurate assessment of his condition because of the overall deterioration of his general health and his inconsistent efforts. Two of the three most recent "qualifying" PFS were invalid. Moreover, these physicians agreed that even if the miner had CWP, it would not have

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record as a whole.

[31] *See, Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997), wherein the Court held that a rule of absolute deference to treating and examining physicians is contrary to its precedents. *See also, Amax Coal Co. v. Franklin*, 957 F.2d 355 (7th Cir. 1992) where the court criticized the administrative law judge's crediting of a treating general practitioner, with no apparent knowledge of CWP and no showing that his ability to observe the claimant over an extended time period was essential to understanding the disease, over an examining Board-certified pulmonary specialist bordered on the irrational. The Court called judge's deference to the "treating physician" over a non-treating specialist unwarranted in light of decisions such as *Richardson v. Perales*, 402 U.S. 389, 91 S.Ct. 1420, 28 L.Ed.2d 842 (1971); *Garrison v. Heckler*, 765 F.2d 710, 713-15 (7th Cir. 1985); and, *DeFrancesco v. Bowen*, 867 F.2d 1040, 1043 (1989).

caused him any impairment.

Mr. Rayner's records of hospitalization and treatment, as well as the opinions of Drs. Fino, Rosenberg, and Altmeyer, establish that he suffered from significant cardiovascular afflictions, including CAD, CHF or cardiac decompensation, hypertension, vascular congestion, and worsening renal failure. He had suffered earlier MIs, had a pacemaker implanted and had undergone CABG, in 1990. It is agreed, among these pulmonary experts that he suffered from a mild-to-moderate, reversible, obstructive airways disease due to his long history of cigarette smoking.

I find the claimant has not met her burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. Nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d730, 17 B.L.R. 2-64 (3d Cir. 1993).

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since the miner had ten years or more of coal mine employment, the claimant would ordinarily have received the benefit of the rebuttable presumption that the miner's pneumoconiosis arose out of coal mine employment. However, in view of my finding that the existence of CWP has not been proven this issue is moot. Moreover, the presumption is rebutted by the medical opinion evidence discussed herein.

D. Existence of total disability due to pneumoconiosis

The claimant must show the miner's total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).[32] Sections 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood

[32] § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states:

(a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

gas studies with qualifying values; (iii) evidence the miner has pneumoconiosis and suffers from cor pulmonale with right-sided congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony.[33] Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no credible evidence that the miner suffers from cor pulmonale with right-sided congestive heart failure. Dr. Georges' sole reference to cor pulmonale is both undocumented and unreasoned. § 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miner's claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. Of the miner's six PFS, three were "non-qualifying" and two of the three "qualifying" PFS were invalid. None of the three best-qualified physicians found Mr. Rayner totally disabled. Only Dr. Wintzer found total disability, but relied on a non-qualifying PFS. The reliability of the one remaining "qualifying" PFS, in 1998, is doubtful due to Mr. Rayner's deteriorating overall health. Thus, I find total respiratory disability is not established by PFS evidence.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b)(2)(ii). All the miner's AGS reflected "non-qualifying" results.

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b). Under this subsection, " . . . all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Camp Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director,*

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[33] In a living miner's claim, lay testimony "is not sufficient, in and of itself, to establish disability." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994). See 20 C.F.R. § 718.204(d)(5)(living miner's statements or testimony insufficient alone to establish total disability). But, pre-death statements of a now deceased miner "shall be considered" in determining whether the miner was totally disabled at the time of death. 20 C.F.R. § 718.204(d)(4).

OWCP, 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

A medical opinion based on an invalid study may be rejected. *See Director v. Siwiec*, 894 F.2d 635, 639 (3d Cir. 1990)(cited with approval in *Lane v. Union Carbide & Director, OWCP*, 21 B.L.R. 2-34, 2-47, 105 F.3d 166 (4th Cir. 1997).

The Fourth Circuit rule is that "nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis." *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994). In *Milburn Colliery Co. v. Director, OWCP,[Hicks]*, 21 B.L.R. 2-323, 138 F.3d 524, Case No. 96-2438 (4th Cir. Mar. 6, 1998) *citing Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994), the Court had "rejected the argument that '[a] miner need only establish that he has a total disability, which may be due to pneumoconiosis in combination with nonrespiratory and nonpulmonary impairments.'" Even if it is determined that claimant suffers from a totally disabling respiratory condition, he "will not be eligible for benefits if he would have been totally disabled to the same degree because of his other health problems." *Id.* at 534.

The Benefits Review Board has held that nonrespiratory and nonpulmonary impairments are irrelevant to establishing total disability, under 20 C.F.R. § 718.204. *Beatty v. Danri Corp.*, 16 B.L.R. 1-1 (1991).

Dr. Wintzer stands alone as the only physician to diagnose a total respiratory disability arising out of coal mine dust exposure, in 1991. No physician since then found so, in particular the very well qualified pulmonary specialists, Drs. Fino, Altmeyer, and Rosenberg. All the latter had a much better picture of the miner's health than Dr. Wintzer. Moreover, Dr. Wintzer lacked the objective test results, i.e., a PFS, upon which to soundly base such an opinion. I thus do not find the medical opinion evidence establishes a total respiratory disability due to CWP. If Mr. Rayner was debilitated, it was due to his significant cardio-vascular afflictions and renal failure.

I find the claimant has not met her burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff'g sub. Nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d730, 17 B.L.R. 2-64 (3d Cir. 1993).

E. Cause of total disability[34]

The revised regulations, 20 C.F.R. § 718.204(c)(1), requires a claimant establish his

[34] *Billings v. Harlan #4 Coal Co.*, ___ B.L.R. ___ , BRB No. 94-3721 (June 19, 1997). The Board has held that the issues of total disability and causation are independent; therefore, administrative law judges need not reject a Doctor's opinion on causation simply because the doctor did not consider the claimant's respiratory impairment to be totally disabling.

pneumoconiosis is a "substantially contributing cause" of his totally disabling respiratory or pulmonary disability. The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) and (ii), adding the words "material" and "materially", results in "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." 65 Fed. Reg. No. 245, 79946 (Dec. 20, 2000).[35]

The Fourth Circuit Court of Appeals requires that pneumoconiosis be a "contributing cause" of the claimant's total disability.[36] *Toler v. Eastern Associated Coal Co.*, 43 F. 3d 109, 112 (4th Cir. 1995); *Jewel Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994). In *Street*, the Court emphasized the steps by which the cause of total disability may be determined by directing "the Administrative Law Judge [to] determine whether [the claimant] suffers from a respiratory or pulmonary impairment that is totally disabling and whether [the claimant's] pneumoconiosis contributes to this disability." *Street*, 42 F.3d 241 at 245. The Board requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Scott v. Mason Coal Co.*, 14 B.L.R. 1-37 (1990)(*en banc), overruling Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988).

"A claimant must be totally disabled due to pneumoconiosis and any other respiratory or pulmonary disease, not due to other non-respiratory or non-pulmonary ailments, in order to qualify for benefits." *Beatty v. Danri Corp. & Triangle Enterprises*, 16 B.L.R. 1-11 (1991) *aff'd* 49 F.3d 993 (3d Cir. 1995) *accord Jewell Smokeless Coal Corp.*.(So, one whose disability is only 10% attributable to pneumoconiosis would be unable to recover benefits if his completely unrelated physical problems (i.e., stroke) created 90% of his total disability).

If the miner would have been disabled to the same degree and by the same time in his life had he never been a miner, then benefits cannot be awarded. *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 990); *Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990).[37] The evidence establishes just that here.

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[35] Effective January 19, 2001, § 718.204(a) states, in pertinent part:
For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

[36] *Hobbs v. Clinchfield Coal Co.* 917 F.2d 790, 792 (4th Cir. 1990). Under *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 at 2-76, 914 F.2d 35 (4th Cir. 1990), the terms "due to," in the statute and regulations, means a "contributing cause.," not "exclusively due to." In *Roberts v. West Virginia C.W.P. Fund & Director, OWCP*, 74 F.3d 1233 (1996 WL 13850)(4th Cir. 1996)(Unpublished), the Court stated, "So long as pneumoconiosis is a 'contributing' cause, it need not be a 'significant' or substantial' cause." Id.

[37] "By adopting the 'necessary condition' analysis of the Seventh Circuit in *Robinson*, we addressed those claims . . . in which pneumoconiosis has played only a *de minimis* part. *Robinson*, 914 F.2d at 38, n. 5." *Dehue Coal Co. v. Ballard*, 65 F.3d 1189, 1195 n. 8 (4th Cir. 1995).

F. Death due to Pneumoconiosis

Subsection 718.205(c) applies to survivor's claims filed on or after January 1, 1982 and provides that death will be due to pneumoconiosis if any of the following criteria are met:

> (1) competent medical evidence established that the miner's death was caused by pneumoconiosis; or
>
> (2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or
>
> (3) the presumption of § 718.304 [complicated pneumoconiosis] is applicable.

20 C.F.R. § 718.205(c). Criteria (1) and (3) are not applicable in this case; criterion (2) is met.

The Board concludes that death must be "significantly" related to or aggravated by pneumoconiosis, while the circuit courts have developed the "hastening death" standard which requires establishment of a lesser causal nexus between pneumoconiosis and the miner's death. *Foreman v. Peabody Coal Co.*, 8 B.L.R. 1-371, 1-374 (1985). The regulation now provides that "[P]neumoconiosis is a 'substantially contributing' cause of death if it hastens the miner's death." 20 C.F.R. § 718.205(c)(5). The United States Court of Appeals for the Third Circuit has also held that any condition that *hastens* the miner's death is a substantially contributing cause of death for purposes of § 718.205. *Lukosevicz v. Director, OWCP*, 888 F.2d 1001, 1006 (3d Cir. 1989). [38]

Survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. 20 C.F.R. § 718.205(c)(4); *Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988) (survivor not entitled to benefits where the miner's death was due to a ruptured abdominal aortic aneurysm).

The Act and Regulations do not require that pneumoconiosis be the sole, primary or proximate cause of death, but rather that where the principal cause of the miner's death was not pneumoconiosis, that the evidence establish it was a "substantially contributing cause." 20 C.F.R. § 718.205(c)(4). *See, Lukosevicz v. Director, OWCP*, 888 F.2d 1001, 1005 (3rd Cir. 1989)(quoting 48 Fed. Reg. 24,276, 24,277(1), (n)(1983)).

The death certificate states that the cause of death was pneumonia with other significant

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[38] The Fourth, Sixth, Seventh, Tenth and Eleventh Circuits have adopted this position in *Shuff v. Cedar Coal Co.*, 967 F.2d 977 (4th Cir. 1992), *cert. den.*,506 U.S. 1050, 113 S.Ct. 969 (1993); *Brown v. Rock Creek Mining Corp.*, 996 F.2d 812 (6th Cir. 1993)(J. Batchelder dissenting); and *Peabody Coal Co. v. Director, OWCP*, 972 F.2d 178 (7th Cir. 1992); *Northern Coal Co. v. Director, OWCP*, 100 F.3d 871 (10th Cir. 1996); *Bradberry v. Director, OWCP*, 117 F.3d 1361, 21 B.L.R. 2-166 (11th Cir. 1997).

conditions listed as stroke and ischemic cardiomyopathy. There is no indication that Dr. Holloway, who signed the certificate, had any specialized knowledge or any specific knowledge of the miner. Thus, his statement is of little value. In any case, he does not mention CWP. Nor does the miner's terminal admission discharge record prepared by Dr. Georges. Dr. Georges is the only doctor to say CWP contributed to the miner's death. But, his deposition testimony clearly establishes he was unqualified to make such a determination. Moreover, it is contrary to the opinions of three highly-qualified pulmonary specialists, Drs. Fino, Rosenberg and Altmeyer.

Dr. Rosenberg related the cause of death best when he wrote:

> He was an 85-year old gentleman who had multiple organ failure to his kidneys, his heart, his brain, multiple strokes and TIAs . . . gangrenous foot requiring amputation. Unfortunately, he died, but it was a natural progression of multiple medical conditions that he had. It really wasn't related to a coal workers' pneumoconiosis or any primary lung condition. (Dep. 28).

Mr. Rayner's death was due to his underlying cardiac condition with aspiration pneumonias, renal insufficiency and a general deteriorating state, as Drs. Rosenberg, Altmeyer and Fino concluded. It was not contributed to nor hastened by any occupational lung disease.

CONCLUSIONS

In conclusion, the claimant has not established that a material change in conditions has taken place since the previous denial. It is not established the miner had pneumoconiosis, as defined by the Act and Regulations. It is not established the miner was totally disabled due to pneumoconiosis. Finally, it is not established that the miner's death was caused by or contributed to by CWP. The Claimant is therefore not entitled to benefits.

ORDER[39]

It is ordered that the claims of Virginia Rayner, survivor of and on behalf of Raymond Rayner for benefits under the Black Lung Benefits Act are hereby DENIED.

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[39] § 725.478 Filing and service of decision and order (Change effective Jan. 19, 2001).

Upon receipt of a decision and order by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

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RICHARD A. MORGAN
Administrative Law Judge

RAM:dmr

PAYMENT IN ADDITION TO COMPENSATION: 20 C.F.R. § 725.530(a)(Applicable to claims adjudicated on or after Jan. 20, 2001) provides that "An operator that fails to pay any benefits that are due, with interest, shall be considered in default with respect to those benefits, and the provisions of § 725.605 of this part shall be applicable. In addition, a claimant who does not receive any benefits within **10 days** of the date they become due is entitled to additional compensation equal to **twenty percent** of those benefits (see § 725.607)."

NOTICE OF APPEAL RIGHTS (**Effective Jan. 19, 2001**): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e, at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601**.[40] A copy of a Notice of Appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, at the Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

[40] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001).

(d) Regardless of any defect in service, **actual receipt** of the decision is sufficient to commence the 30-day period for requesting reconsideration or appealing the decision.